CENTERSTO	R MEDICARE & MEDIC	AID SERVICES			OWI	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIG	00	COMPL	ETED
		15G495	A. BUILDING		09/16/20	011
			B. WING			
NAME OF I	PROVIDER OR SUPPLIER	t		EET ADDRESS, CITY, STATE, ZIP CODE		
				38 GRAHAM RD		
REM-IND	DIANA INC		IND	DIANAPOLIS, IN46220		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULI	D BE	COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	OPRIATE	DATE
	REGUESTION ON	zge izz.viii i i ve i vi e i i i e i i i e i vi	1 110	· · · · · · · · · · · · · · · · · · ·		D.III
W0000						
	This visit was for the a licensure survey.	annual recertification and state	W0000	ı		
	Survey dates: 9/6/11, 9/16/11.	9/7/11, 9/8/11, 9/9/11, 9/13/11 and				
	Facility Number: 00 Provider Number: 1 AIMS Number: 1002	5G495				
	Surveyor: Keith Briner, Medica	al Surveyor III				
	accordance with 43 Quality Review com	pleted 9/23/11 by Chris rveyor Supervisor and Ruth				
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (client #4), the facility failed to implement its policy and procedures regarding the potential neglect of client #4.  Findings include:  Observations were conducted at the group home on 9/7/11 from 6:00 AM through		W0149	The Program Directtor complereview of all consumers incluction Clientt#4, diett orders and Mareview diettary need restrict well as if any consumers had allergies. All sttafl will receive rettraining on all consumers orders and allergy listts Traininclude the need to ensure substitute flood ittems are consumer is allerication.	uding ARs tto tons as any e diett ng will tthatt oflered ifl	10/16/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001009

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) I			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	I DING	00	COMPL	ETED
		15G495	B. WIN			09/16/2	011
		l .	B. WII.		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	₹		1	RAHAM RD		
REM-INI	DIANA INC			1	APOLIS, IN46220		
		CTATEMENT OF DEFICIENCIES		ID	,		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
0	<b>+</b>	#4 was observed in the		0	For flour weeks tthe Home Manag	er	DITE
		oughout the observation			and/or Program Directtor will	,	
	1 * *	•			complette mealttme observattons	att	
	1 ^	AM client #4 participated			leastt ttwo ttmes per week tto obs		
	1	ining with his peers for			ifl sttafl are flollowing diett orders	and	
		al. Client #4 was offered			nott oflering consumers ittems tth	ey	
		part of his menu meal.			are known tto have an allergic		
	1 *	the orange slices on his			reactton tto and make sure sttafl a		
	plate and consur	ned his portion of french			oflering appropriatte substtttuttes	as	
	toast which was	also located on the plate			needed.		
	with the orange	slices. Client #4 was not			Ongoing tthe Home Manager and Program Directtor will complette	OI	
	observed eating	the orange slices. PD #1			mealttme observattons att leastt o	ne	
		or), HM #1 (Home			ttme per week tto observe ifl sttaf		
		#1, staff #2 and/or staff #3			flollowing diett orders and nott		
		ed prompting client #4 to			oflering consumers ittems tthey ar	re e	
		ge slices from his plate,			known tto have an allergic reactto	n tto	
	or offer an altern	• •			and make sure sttafl are oflering		
					appropriatte substtttuttes as need		
	The facility's no	sted Week 4, Summer			Responsible Partty Directt Support sttafJ Home Manager, Program	.τ	
	1	wed on 9/7/11 at 6:20			Directtor		
		included but was not			J. Cetto		
		ed orange for the breakfast					
	meal on 9/7/11.						
	G1: 4 //4!	1 0/0/11					
		d was reviewed on 9/8/11					
		ent #4's ISP (Individual					
		ated 8/1/11 indicated his					
	_	s included but was not					
		's syndrome and severe					
		oility. Client #4's ISP					
	indicated he was not independent with						
	meal time choices and/or behavior and						
	needed support i	n order to maintain					
	healthy nutrition	. Client #4's Nutritional					
	1 -	ent dated 8/1/11 indicated					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE S COMPL 09/16/2	ETED
	PROVIDER OR SUPPLIER			6338 GF	DDRESS, CITY, STATE, ZIP CODE RAHAM RD APOLIS, IN46220	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	client #4 had a for strawberries and	ood allergy to oranges/orange juice.					
	PM indicated cli oranges as part of 9/7/11. HM #1 in have a food aller potential for an a indicated client # the risks associat oranges.  Interview with P PM indicated cli offered food item The facility's powere reviewed The facility's 6/ procedure entit Management in "A service deliving compromises to an individual w receiving service causes: Event	led Quality Risk ndicated the following,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G495	B. WIN		<del></del>	09/16/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RAHAM RD		
DEM IND	DIANA INC				APOLIS, IN46220		
KEWI-IINL	MANA INC			INDIAN	AFOLIS, IN40220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
W0153	-	nsure that all allegations of					
	-	lect or abuse, as well as					
	•	n source, are reported					
	•	administrator or to other					
		ance with State law through					
	established proced	w and interview for 1 of 8	1 ,,,	11.52			10/16/2011
		istreatment and/or injury of	W	0153	All directt care sttafl working att tt	nis	10/16/2011
		ved, the facility failed to report an			home will receive rettraining on		
	_	ent aggression for clients #6 and			incidentt reporttng requirementts		
		the administrator, and to the			including whatt incidentts need tto		
		, Aging and Rehabilitative			reportted designatted ttmeflrames		
	Services (DDARS)/E	BDDS (Bureau of bilities Services) per 431 IAC			which incidentts are tto be reportt		
		o Adult Protective Services			and tthe procedure flor immediatt	•	
	(APS) per IC 12-10-				nottflying tthe on call supervisor o	ΤΙ	
					reporttable incidentts	_	
	Findings include:				The Home Manager will complette	e a	
	The feelith to be stated	A			tthorough review ofl consumers		
		t reports, reportable incident tigations were reviewed on			records including Daily Supportt		
		The review indicted the			records, Medical Administratton		
	following:				Records, behavior ttracking and narrattve nottes a minimum oß		
					ttmes per week flor2 montths tto		
		ed on 3/16/11 indicated on			ensure tthatt all incidentts tthatt fl	all	
	involved in a physical	ent #6 and client #8 were			under tthe BDDS reporttable	ali	
	ilivolved ili a pilysical	antercation.			guidelines are reportted tto tthe		
	Interview with adminis	strative staff#1 on 9/7/11 at 1:38			Program Directtor witthin tthe		
	PM indicated all BDD	S reportable incidents are			designatted ttmeflrames		
	11	d by staff within 24 hours of the			Afler tthe2 montth period tthe HM		
		ve staff #1 indicated incidents of			will complette a tthorough review		
	reportable incidents.	ion are considered BDDS			consumers records including Daily		
	reportative merdents.				Supportt records Medical		
	1.1-3-2(a)				Administtratton Records behavior		
					ttracking and narrattve nottes a		
					minimum ofl 1ttme per week tto		
					ensure tthatt all incidentts tthatt fl	all	
					under tthe BDDS reporttable		
					guidelines are reportted tto tthe		
					Program Directtor witthin tthe		
					designatted ttmeflrames		
					For 2 montths tthe Program Direct	tor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nia	00	COMPL	ETED
		15G495	A. BUILD	ING		09/16/2	011
			B. WING				
NAME OF F	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			DDRESS, CITY, STATE, ZIP CODE		
DEM 1315					RAHAM RD		
REM-INL	DIANA INC			INDIANA	APOLIS, IN46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T .	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
					will complette a tthorough review	ofl	
					consumers records including Daily		
					Supportt records Medical		
					Administtratton Records behavior		
					ttracking and narrattve nottes a		
					minimum ofl 1ttme per week tto		
					ensure tthatt all incidentts tthatt fl	all	
					under tthe BDDS reporttable		
					guidelines are reportted tto tthe		
					Program Directtor witthin tthe		
					designatted ttmeflrames		
					The Program Directtor will receive		
					rettraining on QMRP responsibilitt	es	
					including ensuring tthatt		
					documenttatton of BBDS reportta	ble	
					incidentts are reportted tto tthe		
					Administtrattor witthin designatte	d	
					ttmeflrames and ensuring tthatt re	esultts	
					ofl any needed investtgattons are		
					being reportted tto tthe administt	rattor	
					witthin 5business days ofl tthe		
					incidentt		
					Ongoing tthe Area Directtor will		
					review all BDDS reportts and		
					investtgattons tto ensure tthatt		
					incidentts are being reportted tto	tthe	
					administtrattor witthin designatted	d ttme	
					flrames and tthatt needed		
					investtgattons are reportted tto ttl		
					administtrattor witth husiness da	iys	
			1		ofl tthe incidentt		
					Responsible Partty Home Manage	er,	
			1		Program Directtor Area Directtor		
11/01/00	The feeith,	rovido opob ompleves with		-	Qualitty Assurance Specialistt		
W0189		provide each employee with					
		ng training that enables the orm his or her duties					
		ntly, and competently.					
		review and interview for	W01	189	Since documenttatton could nott b	ne l	10/16/2011
	Dascu on record	icvicw and interview ith	""	107	secured thatt documentted thatt		10/10/2011
					secured unau abcumentica tiliati	Juan	

001009

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	LETED
		15G495	B. WIN			09/16/2	011
NAME OF	DDOLUDED OD GUDDUIEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF	PROVIDER OR SUPPLIER	C		6338 G	RAHAM RD		
	DIANA INC			INDIAN	IAPOLIS, IN46220		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	1 *	lients (#1, #2, #3 and #4)			#1 had successflully passed Core A and Core B curriculum when hired		
	1 ^	clients (#5, #6, #7 and			Sttaff#1 received rettraining on Co	•	
	1 ''	failed to ensure a facility			A and Core B curriculum on 10/4/		
	1	ned in medication			The Home Manager and Program		
		and to ensure facility			Directtor will receive rettraining o	n	
	staff was traine	•			ensuring tthatt all sttafl working in	n tthe	
	1	ministration prior to			home have been ttrained on tthe	Core	
	working alone	with clients.			A and Core B curriculum prior tto		
					working in tthe group home alone		
	Findings include	<b>:</b> :			witth consumers and prior tto pas any consumers medicattons.	sing	
					Ongoing tthe Home Manager and		
	Staff #1's emplo	yee file was reviewed on			Program Directtor will work witth		
	9/7/11 at 1:40 PI	M with administrative			Human Resources sttafl tto ensure		
	staff #1. Staff #1	's employee file did not			tthatt all sttafl have successflully p	assed	
	1	had completed and			Core A and Core B curriculum pric	or	
	1	sed Core A and/or Core B			tto tthem being allowed tto work	in	
	1	inistration training within			tthe home alone witth consumers		
	1	day timeframe. Staff #1's			prior tto tthem passing any consu	mers	
	1 ^	a hire date of 11/20/10.			medicattons.  Responsible Partty Home Manage		
	record marcuted	a fine date of 11/20/10.			Program Directtor Human Resource		
	Intervious swith a	dministrative staff #1 on			Sttafl		
	1	M indicated staff #1 was a					
	1	yed by the facility but was					
	•	of Absence) due to					
	1 ^	. Administrative staff #1					
	1	1 had been employed with					
	1	11/20/10 and should					
	have received m	edication administration					
	training during t	he initial orientation					
	process. Administrative staff #1 indicated						
	all staff working in the group home with						
	the clients are re	quired to successfully					
	complete Core A	and Core B curriculum					
	prior to working	with the clients alone.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G495	A. BUILDING B. WING		09/16/2011
	PROVIDER OR SUPPLIER		6338 G	NDDRESS, CITY, STATE, ZIP CODE RAHAM RD APOLIS, IN46220	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	had been working her hire date and clients alone throemployment.  Interview with H on 9/7/11 at 2:45 should have been Core B curriculur group home alon indicated staff #1	taff #1 indicated staff #1 g with the clients since had worked with the bughout her time of  M (Home Manager) #1 PM indicated staff #1 n trained on Core A and m prior to working in the e with the clients. HM #1 had been working with ghout her employment			
	#1 on 9/7/11 at 2 should have been Core B curriculur group home alon indicated staff #1 the clients through with the facility.	D #1 (Program Director) :50 PM indicated staff #1 in trained on Core A and imprior to working in the e with the clients. HM #1 had been working with ghout her employment PD #1 indicated staff #1 implete the training prior es at the group home.			
	1.1-3-3(a)				
W0218	must include sens Based on observa interview for 1 o	re functional assessment orimotor development. ation, record review and f 4 sampled clients (client ailed to ensure a current	W0218	Clientt#2 has been reflerred tto tth Rehab Hospittal ofl Indiana An assessmentt will be scheduled att earliestt datte The Program Directt	tthe

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G495	B. WIN			09/16/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEM INI	DIANA INO			1	RAHAM RD		
	DIANA INC			INDIAN	APOLIS, IN46220		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)	1	TAG	·		DATE
		SMA (Sensorimotor			will convene tthe IDT flollowing ttl assessmentt tto address tthe	ie	
	1	assessment to meet the			recommendattons.		
	client's needs.				The Program Directtor will receive		
					rettraining on assessmentt		
	Findings include	2:			requirementts tto include tthe nee	ed flor	
		1 . 1 1			a sensorimottor assessmentt Once		
		ere conducted at the group			recommendattons are received flr		
		from 5:00 PM through			tthe assessmentt and tthe IDT has tto discuss recommendattons the		
		9/7/11 from 6:00 AM			Program Directtor will develop go		
		A. Client #2 was observed			as needed and ttrain sttafl on any		
	in the group home throughout both				recommendattons tto ensure ttha	tt	
	1 ^	ods. Client #2 was			Clientt#2 receives appropriatte		
	1 .	d in that he was blind and			assisttance in becoming more		
	1	On 9/6/11 at 6:00 PM			independentt att mealttmes		
	1	ompted by staff to come		Ongoing tthe Area Directtor will review tthe nextB ISPs written by tthe	the		
	_	om to participate in family			Program Directtor tto ensure tthat		
	style dining. Cli	ent #2 was offered a plate,			Comprehensive Functtonal		
	silverware and c	up to use for his meal.			Assessmentts are completted prio	r tto	
		rved spaghetti with sauce,			tthe ISP and specifically include		
	1 '	fruit. Client #2 used his			sensory/mottor developmentt		
	fork to scoop the	e spaghetti from his plate			Responsible Partty Program  Directtor Area Directtor		
	to his mouth. As	client #2 used the fork in			2cotto, / ii cu Directioi		
		spaghetti would slide off					
	1	late. Client #2 then began					
	utilizing his fing	ers to hold the spaghetti					
	_	used his fork to scoop					
	the food. Client	#2 was then offered a					
	bowl to use in or	rder to prevent the food					
		ed off of the plate and					
	client #2 from us	sing his hands.					
	On 9/7/11 at 7:0	7 AM client #2 was					
	prompted to con	ne to the dining room					
	table to participa	nte in family style dining					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI 09/16/2	LETED
	PROVIDER OR SUPPLIER		D. WIW	STREET A	DDRESS, CITY, STATE, ZIP CODE RAHAM RD APOLIS, IN46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	plate, silverware his meal. Client #2 used his fork from his plate to used the fork in toast pieces would plate. Client #2 tfingers to hold that as he used his for Client #2 was the in order to prever pushed off of the using his hands, observed using a plate or other ada equipment.  Interview with H on 9/7/11 at 2:33 visual impairmer him to scoop foo separated on his consumption. HM generally offer him of a plate. HM # know of any receadaptive devices client #2. HM #1 would benefit from	M (Home Manager) #1 PM indicated client #2's ats make it difficult for d and keep foods					

001009

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495		LDING	00	COMPL 09/16/2	ETED
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE RAHAM RD APOLIS, IN46220	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on 9/7/11 at 2:40 also observed cliusing the fork an observations. PD know of any SM client #2 to deter and/or a divided appropriate. PD would benefit from the second second with the second at 1:23 PM. Client #2's recommendation (Individual Supplementation of the second seco	#1 indicated client #2 om an SMA.  S (Administrative Staff) :44 PM indicated client current SMA to assess dependence.  d was reviewed on 9/7/11 nt #2's record indicated a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		COMPLETED	
AND PLAN	OF CORRECTION		A. BUILDING	00	09/16/2011
		15G495	B. WING		09/16/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DEM INI	NAMA INO			RAHAM RD	
REM-INL	DIANA INC		INDIAN	IAPOLIS, IN46220	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0259	functional assessn reviewed by the in relevancy and upd				10/16/2011
		review and interview for	W0259	The Program Directtor will receive	
		lients (#4), the facility		rettraining on tthe need tto ensur	
	failed to ensure c	lient #4 had a CFA		tthatt all consumers have current Comprehensive Functional	
	(Comprehensive Fun annually.	ctional Assessment) updated		Assessmentts and tthatt tthese ar uttlized in tthe developmentt ofl	re
	Findings include:			ttraining objecttves Ongoing tthe PD will ensure tthat	t all
		as reviewed on 9/8/11 at 12:40 ord indicated a CFA dated		om in	
	Interview with AS (Administrative Staff) #1 on 9/9/11 at 1:32 PM indicated there were no additional CFA for review for client #4.			assessed in tthe CFA tto assistt tth becoming more independentt Ongoing tthe Area Directtor will review tthe nextB ISPs written by	
	1.1-3-4(a)			Program Directtor tto ensure ttha goals/objecttves are developed ensure consumers are working or	
				ttasks tthatt will allow tthem tto be more independentt	
				Responsible Partty Program	
W0436	repair, and teach of informed choices a eyeglasses, hearing communications a devices identified las needed by the or information of the communications.	ids, braces, and other by the interdisciplinary team client.		Directtor Area Directtor	
	record review for (#5), the facility	ation, interview and r 1 of 4 sampled clients failed to encourage client to use dentures.	W0436	A goal will be developed flor Clier tto encourage him tto wear his denttures Clientt#4 ISP will be updatted tto reflectt tthe goal tto encourage tthe dentture wearAll sttafl will receive rettraining on Cl #4 goal tto encourage him tto we	ientt

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		15G495	A. BUII B. WIN	LDING IG		09/16/2	011
REM-IND	PROVIDER OR SUPPLIER			6338 G	ADDRESS, CITY, STATE, ZIP CODE RAHAM RD APOLIS, IN46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	home on 9/6/11 for 6:30 PM and on through 8:00 AM in the group home observation periodedentulous in region client #4 was not upper dentures. In Director), HM # #1, staff #2, staff #5 were not observation client with HAM indicated client dentures. HM #1 should be encouraging client #5's record 9/7/11 at 9:40 Al (Individual Suppindicated the use ISP did not indicobjective to teach wear his dentures.	1 (Home Manager), staff (#3, staff #4 and/or staff erved prompting or nt #5 to use his dentures.  IM #1 on 9/9/11 at 11:18 tent #5 refuses to wear his indicated client #5 raged and/or trained to  d review was reviewed on M. Client #5's ISP fort Plan) dated 5/23/11 for dentures. Client #5's ate a formal training th client #5 to use and/or ss.			denttures Once sttafl are ttrained on Client44 dentture goaJ tthe Home Manager and/or Program Directtor will complette active ttreattmentt observations a minimum of 12 ttme per week tto ensure tthatt tithe go being implementted The Program Directtor will receive rettraining on tithe need tto ensure tthatt goal/sobjectives are develope as needed tto ensure consumers a working on ttasks tthatt will allow tthem tto become more independ Ongoing tithe Area Directtor will review tithe next8 ISPs written by t Program Directtor tto ensure tthat goals/objectives are developed ensure consumers are working on ttasks tthatt will allow tithem tto be more independentt Responsible Partty Home Manage Program Directtor, Area Directtor	es al is ed are entt the t	
W0460		eceive a nourishing, including modified and ed diets.					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
		15G495	A. BUILDING		-	09/16/2011	
			B. WIN		DDDEGG CONV. CTATE TIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
				1	RAHAM RD		
REM-INDIANA INC				INDIAN	APOLIS, IN46220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
			l w	0460	The Program Directtor completted	l a	10/16/2011
					review ofl all consumers including		
		on, interview and record review			Clientt#4, diett orders and MARs t		
	1	clients (client #4), the facility			review diettary need resttricttons		
		client's diet by serving him a			well as ifl any consumers had any		
	food he was allergic	c to.			allergies. All sttafl will receive		
	Findings in the 4				rettraining on all consumers' diett	.	
	Findings include:				orders and allergy listts Training w		
	Observations were	conducted at the group home			include tthe need tto ensure tthatt		
		0 AM through 8:00 AM. Client			substtttutte flood ittems are oflered ifl		
		the group home throughout the			sometthing a consumer is allergic	tto	
		At 7:20 AM client #4			is oflered on tthe menu		
					For flour weeks tthe Home Manag	er	
	participated in family style dining with his peers for the morning meal. Client #4 was offered				and/or Program Directtor will		
	orange slices as part of his menu meal. Client #4		complette mealttme observattons att		att		
	placed the orange slices on his plate and consumed		leastt ttwo ttmes per week tto observe				
	his portion of french toast which was also located				ifl sttafl are flollowing diett orders		
	on the plate with the orange slices. Client #4 was				nott oflering consumers ittems tth		
		the orange slices. PD #1			are known tto have an allergic	<i>'</i>	
	_	, HM #1 (Home Manager),			reactton tto and make sure sttafl a	are	
	staff #1, staff #2 and/or staff #3 were not observed			oflering appropriatte su		as	
	prompting client #4 to remove the orange slices		needed.				
	from his plate, or offer an alternative food item.				Ongoing tthe Home Manager and	or	
					Program Directtor will complette		
	The facility's posted Week 4, Summer menu was reviewed on 9/7/11 at 6:20 AM. The menu				mealttme observattons att leastt o	one	
					ttme per week tto observe ifl sttaf	l are	
	included but was not limited to 1 sliced orange for				flollowing diett orders and nott	g diett orders and nott	
	the breakfast meal on 9/7/11.				oflering consumers ittems tthey are		
					known tto have an allergic reactto	n tto	
		vas reviewed on 9/8/11 at 12:40			and make sure sttafl are oflering		
		(Individual Support Plan)			appropriatte substtttuttes as need	ied	
		ted his current diagnosis			Responsible Partty Directt Suppor	tt	
		ot limited to: down's syndrome			sttaf) Home Manager, Program		
		ual disability. Client #4's ISP			Directtor		
		t independent with meal time					
		ivior and needed support in					
		ealthy nutrition. Client #4's Document dated 8/1/11					
		had a food allergy to					
	strawberries and ora	anges/orange juice.	ı				

001009

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING		00		
		15G495			<del></del>	09/16/2011	
			D. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					RAHAM RD		
REM-INDIANA INC					APOLIS, IN46220		
					- TI OLIO, IIV+0220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	indicated client #4 v his morning meal or client #4 did have a had the potential for indicated client #4 is associated with cons	ton 9/8/11 at 1:54 PM hould not be offered food					
W9999	Persons with Development Persons with Development Persons with Development Persons with Development Persons with Persons w	provider shall report the concest to the division by the first business day summaries as requested by the content of the concest of the conce	W9999		All directt care sttafl working att tti home will receive rettraining on incidentt reporting requirementts including whatt incidentts need tto reportted designatted timeflrames which incidentts are tto be reportt and tihe procedure flor immediatt nottflying tihe on call supervisor o reporttable incidentts The Home Manager will complette tthorough review ofl consumers records including Daily Supportt records, Medical Administratton	o be in ed ely fl	10/16/2011
	reportable incidents, the incidents of missed med #8 within 24 hours.  Findings include:  The facility's incident reports and/or inves	t reports, reportable incident tigations were reviewed on The review indicated the			Records, behavior ttracking and narrattve nottes a minimum oß ttmes per week flor2 montths tto ensure tthatt all incidentts tthatt fl under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames  Afler tthe2 montth period tthe HM		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/16/2011		
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN46220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	"It was reported by the [client #7] did not recomissed dosage consist 500 mg and topamax 2 [client #7]' s seizure d  -BDDS report submitt at 7:00 AM client #8 r tegretol (seizure media 8/1/11.  Interview with admini PM indicated all BDD supposed to be reporte incident. Administrati	ed on 3/7/11 indicated on 3/5/11, e oncall house manager that eive his 9pm medications. The ed of lamictal 50 mg, depakote 200 mg, these are all used for isorder."  ed on 8/3/11 indicated on 8/1/11 received 800 mg (milligrams) of cation) instead of 600 mg on  strative staff #1 on 9/7/11 at 1:38 PS reportable incidents are ed by staff within 24 hours of the eve staff #1 indicated missed considered BDDS reportable		will complette a tthorough review consumers records including Dail Supportt records Medical Administtratton Records behavior ttracking and narrattve nottes a minimum off 1ttme per week tto ensure tthatt all incidentts tthatt under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames  For 2 montths tthe Program Direction will complette a tthorough review consumers records including Dail Supportt records Medical Administratton Records behavior ttracking and narrattve nottes a minimum off 1ttme per week tto ensure tthatt all incidentts tthatt under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor within tthe designatted ttmeflrames  The Program Directtor will receive rettraining on QMRP responsibilic including ensuring tthatt documenttatton off BDDS reportincidentts are reportted tto tthe Administrattor witthin designatted ttmeflrames and ensuring tthatt off any needed investigations are being reportted tto tthe administ witthin 5business days off tthe incidentt  Ongoing tthe Area Directtor will review all BDDS reportts and investigations tto ensure tthatt incidentts are being reportted tto administrattor witthin designatted the service of the surface o	flall  cttor v ofl y  flall  e ttes cable ed resultts e ttrattor		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15G495	A. BUILDING	00	COMPLETED 09/16/2011	
		130493	B. WING	A DDDDGG GITTY GTATE ZID GODE	09/10/2011	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6338 GRAHAM RD						
REM-INDIANA INC			INDIAN	IAPOLIS, IN46220		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	TE COMPLETION DATE  the ays	